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Modes and Impact of Coercive Inpatient Treatment for Drug-Related Conditions in Switzerland

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Key Words

Inpatient treatment · Illicit drugs · Court referral · Civil commitment · Treatment outcomes

Abstract

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Introduction

Compulsory care and treatment for drug abuse and dependence include a range of legal, motivational and therapeutic interventions. Weisner [1] has called this the 'coercive continuum', with different types of drug treatment and degrees of pressure on drug users to enter and stay in treatment. In Switzerland, the 'severest' type of compulsory treatment for drug dependence is civil commitment, followed by referrals from the criminal justice system, workplace referrals and pressure from families and friends. Pressure for drug users to enter treatment may also stem from health problems or other drug-related problems without interference from others. In fact, some kind of motivational push is usually involved in any process of entering a treatment program. However, it makes sense to distinguish institutional forms of coercive treatment (based on legislation and defined procedures) from noninstitutional pressure by relatives or employers.

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Types of Institutional Coercion

Swiss legislation provides two main types of institutional coercion for the care and treatment of individuals with drug problems.

The first type is *civil commitment*, based on the Swiss Civil Law (Schweizerisches Zivilgesetzbuch, Art. 397 ff.), called 'Fürsorgerische Freiheitsentziehung' (deprivation of liberty to provide care that otherwise cannot be provided). Such coercive care has to be provided in an 'appropriate institution' that has the necessary therapeutic infrastructure and competence. De facto, this type of civil commitment often means forced hospitalization for drug dependence in a psychiatric hospital.

The commitment can be ordered by a special authority that functions as a court in relation to matters of guardianship (Vormundschaftsgericht) or by physicians authorized by cantonal (canton = Swiss state) regulations or laws. Both special authority and physicians may also just refer the patients to treatment, and only if they refuse is civil commitment enacted.

Physicians must, in all cases of commitment, describe the problems and risks, based on a personal assessment of the patient. The main reasons for ordering civil commitment for drug-related problems are psychiatric conditions (delusional states, psychosis, amnesic syndromes, risk of suicide). The patient has the right to appeal to another court against the commitment [2].

The second type is a referral from the criminal justice system, referred to as *court referral*. Treatment by court referral is based on the Swiss Penal Code (Schweizerisches Strafgesetzbuch, Art. 44). The same provision is made for convictions on the basis of the Swiss Narcotic Law (Betäubungsmittelgesetz). A sentence of imprisonment can be suspended by the court in favor of admitting the convicted person to a regular residential or outpatient treatment program. If treatment fails, the sentence can be reactivated and imprisonment ordered. The convicted person has the right to refuse treatment if he/she prefers to go to prison (e.g. when the duration of imprisonment is much shorter than the planned treatment).

Within the prison system, there are also options for receiving treatment. In most Swiss prisons, methadone maintenance treatment can be continued while serving a prison term, and it can be initiated in a growing number of prisons. In some prisons, a drug-free, therapeutic-community-type treatment is offered in a special unit, and inmates can apply for admittance [3]. Finally, in two prisons, heroin-assisted treatment is offered.

The second type of coercive treatment is therefore always an option that is not practicable without the (silent or expressed) consent of the convicted person or inmate. For this reason, some authors have not subsumed this form of treatment under coercive treatment. However, the alternative is a prison term, so the pressure on the individual to undergo treatment is quite high.

Utilization of Coercive Treatment

There are no comprehensive national figures on the utilization of *civil commitment* for drug-related problems. The Canton of Zurich has released routine statistics that include such figures. According to the Research Report 2000, the proportion of civil commitments in contrast to voluntary (psychiatric) hospitalizations was 33% in general; for persons with drug dependence or other drug-related problems, no exact figure is available but is estimated to be lower [4].

In terms of outpatient treatment for opiate dependence (either heroin or methadone), referrals from the special authority that functions as a court in relation to matters of guardianship (Vormundschaftsgericht) or from entitled physicians constituted less than 2% of the cases in 1998 [5]. Similar numbers were found for outpatient treatment of alcohol dependence. In terms of inpatient treatments for drug abuse, prevalence rates were in the same range including formal civil commitments. Treatment statistics between 1997 and 2000 reported prevalence rates from 0.8 to 3.6% [6–9].

A temporary utilization of civil commitment as an instrument to enforce detoxification of drug-dependent persons, who were arrested in an open drug scene, was started in early 1991 and evaluated in comparison to voluntary residential detoxifications in the same psychiatric hospital. This practice was discontinued after a few months on the basis of high relapse rates after discharge. Patients reappeared in the drug scene, so this application of civil commitment was found to be highly ineffective [10].

In sum, civil commitments have been rather rarely used for drug-dependent individuals in Switzerland, and additionally patients committed to treatment by civil commitment constitute a small minority among the patients in drug therapy.

Referrals from the criminal justice system (i.e. court referrals as defined above) to treatment programs are more prevalent, even though they only concern a small fraction of all convictions based on the Swiss Narcotic

Law. In 1986, 4.3% of all evaluated convictions from 6 major cantons were court referred [11]. In 1989, 3.7% of all offenders were referred to treatment [12]. In 1991, criminal justice system referrals consisted of 2.9% of all convictions (for consumption, trafficking and/or other offences), and in 1994, such referrals accounted for 2.8% of all convictions. The proportion of referrals varies considerably from canton to canton and varied between 0 and 18.5% in 1991, and between 1 and 12.5% in 1994 [13].

The early success of inpatient abstinence-oriented treatment in Switzerland [14, 15] has encouraged judges to make court referrals to treatment an alternative to prison. These referrals are partly against the ideology of abstinence-oriented institutions which have traditionally been based on autonomy and free will. In addition, court referrals have been directed towards methadone maintenance treatment, but up to the year 2000, more referrals went to inpatient institutions [16]. In terms of patient proportions, court referrals amounted to 4–6.5% in outpatient treatment for substance abuse in 1998 [5]. In inpatient drug therapy, court referrals constituted about one third of the clients in the years 1995–1998, compared to 7–8% of the alcohol inpatients and 4–5% of the inpatients in mixed settings. Withdrawal and transfer patients included less than 5% of referred patients (all figures in this paragraph from Herrmann et al. [16]).

This situation has led us to question the role of coerced treatment in inpatient treatment. Specifically two questions will be answered in this paper. Firstly, do court referrals differ systematically from voluntary inpatient treatment? Secondly, do court referral and voluntary patients differ with regard to the length of treatment and discharge characteristics?

Methods

Sample

All patients in the FOS treatment network who entered treatment between 1995 and 1999 were included in the analysis if they fulfilled the criteria listed below. The FOS treatment network has been described in detail elsewhere [8, 17].

Criteria for Inclusion in this Analysis. (a) Existence of treatment entry and discharge data: patients who had not yet finished treatment were excluded from the analysis. (b) Respondents who had indicated that the reason for treatment was a voluntary decision or court referral in the entry questionnaire were included. (c) Individuals with a record of civil commitment were excluded due to small numbers which would not have allowed meaningful statistical tests (see above), and because this group is markedly different from the court referral group.

Table 1. Sampling characteristics of patients included in the current analysis (from all entries into inpatient FOS institutions 1995–1999)

	Number	Percent
Total pool of treatment entries	4,192	100.00
Minus entries not yet discharged (exclusion criterion 1)	952	22.71
Minus entries with only basic data (no data on reason for treatment; exclusion criterion 2)	396	9.45
Minus civil commitments (exclusion criterion 3)	51	1.22
Sample of the current analysis	2,793	66.62

Using these criteria 2,793 patients were included into the analysis (table 1). This sample covers 66.6% of all the treatment entries in Switzerland registered within the FOS treatment network.

Operationalization

Treatment entry and discharge data were collected within the treatment units, by trained staff as part of a routine assessment. At treatment entry, patients were interviewed by means of a standardized questionnaire; at discharge, a member of the staff reported data.

The following variables were included into the analysis: sociodemographic characteristics, education, housing situation before treatment entry, social relationships, drug career, self-reported health status, treatment experiences, legal experiences, length of stay in current treatment, legal situation at discharge, housing situation at discharge, kind of discharge (regular vs. early).

Statistical Analysis

Three groups were separated: voluntary patients, who started therapy without either a court referral or being committed to treatment by civil commitment (VP for voluntary patients; n = 1,882 or 67.4% of the entire sample), patients who expected a court referral and thus started inpatient treatment (CRE for court referral expected; n = 427 or 15.3% of the sample) and patients with court referrals (CR for court referral; n = 484 or 17.3%). Differences between these groups were identified either with table analysis or in case of interval scaled variables with analysis of variance or covariance. As the sample size was large for these statistical tests and almost all of the differences were statistically significant without necessarily being meaningful, we selected an effect size of 20% difference or 1 SD for inclusion in the substantive results of this report. Sociodemographic differences are reported without this criterion.

Results

All details of the analysis can be found in a research report in German [18]. This contribution will only summarize the most important characteristics.

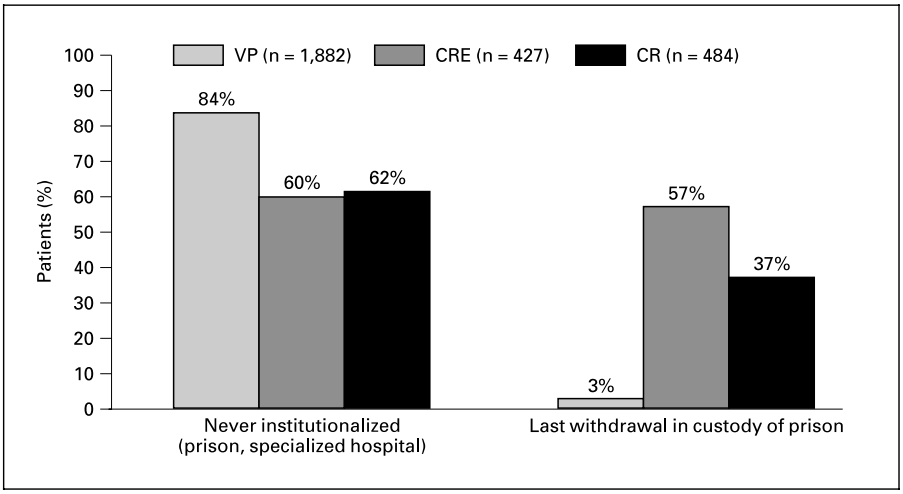

Fig. 1. Housing situation in the last year before entry and place of last withdrawal.

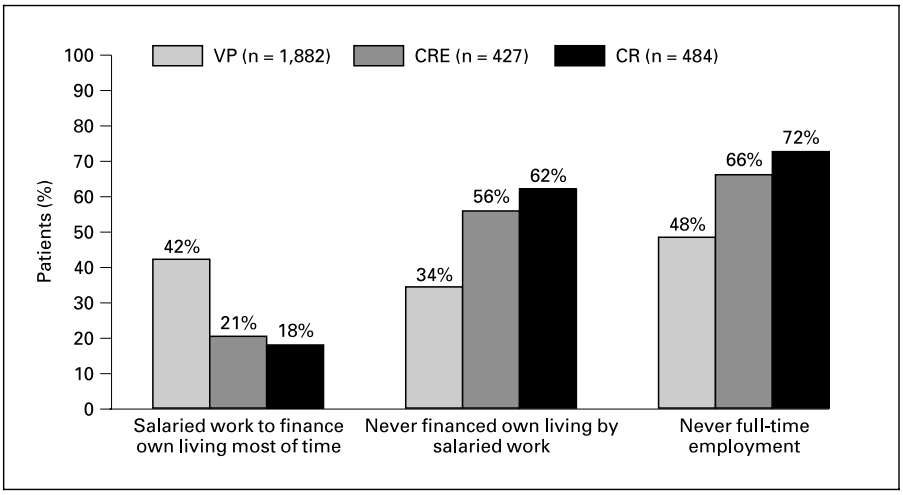

Fig. 2. Employment and financial situation in the year before treatment entry and ever.

Situation at Treatment Entry

In terms of *sociodemographics*, males were more prevalent than females in all three groups. The CR group had the highest proportion of males versus females compared to the other groups (VP 74.4%; CRE 85.9%; CR 86.0%). VP were also slightly older (less than a year difference) and comprised a higher proportion of Swiss citizens. All of these relations were statistically significant, which is not surprising given the high number of patients in each group.

In terms of the *housing situation* in the last year before treatment entry, VP were more likely to be living in or renting an apartment or their own house, to have never been institutionalized or to have undergone their last drug withdrawal in remand or in prison (fig. 1).

As expected, with regard to *employment and financial situation* in the year before treatment, self-referrals were more likely to have had salaried work to finance their living (fig. 2) on a short-term and long-term basis than the other groups.

Prior Treatment Experiences

In terms of prior treatment experiences, CR had fewer voluntary prior inpatient treatment experiences but more coerced ones (fig. 3).

In addition, VP had lower prevalence rates on all measured indicators with regard to legal experiences (fig. 4 for an overview).

Situation at Discharge

Contrary to expectations, there was no difference between the proportions of regular versus irregular dropouts between CR and VP. However, CR stayed in treatment significantly longer than VP (320 days with SD 224 vs.

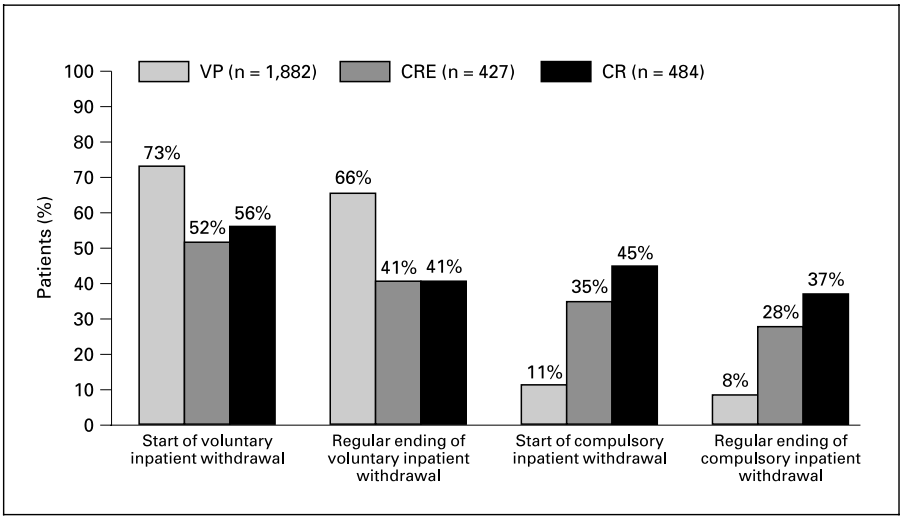

Fig. 3. Prior treatment experiences.

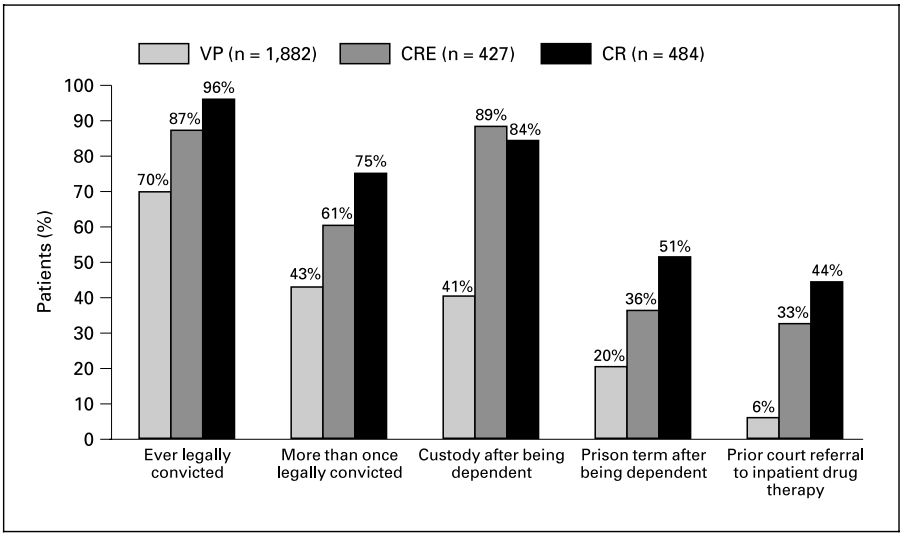

Fig. 4. Past legal experiences.

277 days with SD 200). This finding may be explained by CR considering the prospect of having to go to prison in case of dropping out of treatment early. Also, VP more often had a place to live after discharge (VP 55.6%; CRE 35.6%; CR 39.5%). Another important difference concerned the legal situation at discharge, where VP had markedly fewer legal charges against them at discharge than CR (VP 23.7%; CRE 93.2%; CR 95%). In fact, almost all CR were facing a charge at discharge. No other criterion at discharge showed differences using the effect size criterion specified above. Patients relapsing during treatment were included in the analysis; there were however no significant differences between the groups with regard to overall consumption of addictive drugs (alcohol and tobacco included).

Discussion

VP showed some important differences from CR at treatment entry. In general and not surprisingly, VP seemed to have had less contact with the legal system before treatment independently of the specific treatment court referral. At treatment discharge, not many differences between the groups could be detected. VP seemed to be somewhat better integrated socially in terms of their living situation than the other groups. Otherwise, dropout rates did not differ significantly between the groups, and thus we do not expect drastic differences in treatment success. However, it depends on how treatment success is defined. One of the major concerns is the patients' legal situation after discharge. At discharge from treatment,

CR (including CRE) are often subject to conditional release, patrol supervision, extended correctional measures, persisting charges or pending criminal charges. This may also be the case for VP, however to a much smaller degree (see above). One could speculate that persistent charges and suspended criminal sanctions against discharge patients could easily create situations to trigger relapse to drug use. However, only a follow-up study several months after treatment could possibly give conclusive evidence for this speculation.

Overall, the results indicate that the current situation in Switzerland with court referrals to inpatient treatment seems to work. Patients referred by the court do not seem to have marked differences in the course of treatment or in the situation at discharge. The only exception is legal charges, which seem to be independent of treatment and its course. Maybe a situation could be created whereby such patients come off treatment with a 'clean slate', e.g. where charges related to their prior life are dropped and where they can begin a new life.

References

1 Weisner CM: Coercion in alcohol treatment; in Institute of Medicine (eds): Broadening the Base of Treatment for Alcohol Problems. Washington, National Academy Press, 1990, pp 579–609.
2 Uchtenhagen A: Zur Situation in der Schweiz; in Waller H (ed): Zwangseinweisung in der Psychiatrie. Bern, Huber, 1982, pp 35–46.
3 Karger T: Hilfsangebote für Suchtmittelabhängige in den schweizerischen Straf- und Untersuchungshaftanstalten: Kurzbericht über die Bestandesaufnahme. Im Auftrag des Bundesamtes für Gesundheit. Zürich, Institut für Suchtforschung, 1996.
4 Neuenschwander M, Meyer PC, Hell D: Stationäre Behandlungen in psychiatrischen Institutionen des Kantons Zürich. Forschungsberichte der Psychiatrischen Universitätsklinik Zürich. Zürich, Psychiatrische Universitätsklinik, 2001, vol 6/2.
5 BfS-SFA: Ambulante Suchtberatung 1998: Statistik der ambulanten Behandlung und Betreuung im Alkohol- und Drogenbereich. Neuenburg, Bundesamt für Statistik, 2000.
6 KOFOS: Der Forschungsverbund stationäre Suchttherapie FOS im Jahr 1996. Zürich, Institut für Suchtforschung, 1997.
7 KOFOS: Der Forschungsverbund stationäre Suchttherapie FOS im Jahr 1997: Tätigkeitsbericht und Jahresstatistik der Koordinationsstelle FOS. Zürich, Institut für Suchtforschung, 1998.
8 KOFOS: Der Forschungsverbund stationäre Suchttherapie FOS im Jahr 1998: Tätigkeitsbericht und Jahresstatistik der Koordinationsstelle FOS. Zürich, Institut für Suchtforschung, 1999.
9 KOFOS: Der Forschungsverbund stationäre Suchttherapie FOS im Jahr 1999: Tätigkeitsbericht und Jahresstatistik der Koordinationsstelle FOS. Zürich, Institut für Suchtforschung, 2000.
10 Maier TJ: Die Bedeutung von Zwangsmassnahmen für die Rehabilitation von Drogenabhängigen; medical dissertation, Zürich, 1994.
11 Uchtenhagen A: Anwendung des Betäubungsmittelgesetzes: Auswertung gerichtlicher Verurteilungen in sechs Kantonen. Drog Alkohol 1993;17:209–216.
12 Maag V, Rônez S: Zwanzig Jahre Drogen und Strafrecht. Bern, Bundesamt für Statistik, 1991.
13 Rônez S, Fink D: Drogen und Strafrecht in der Schweiz: Ergebnisse zweier Sondererhebungen 1991 und 1994. Bern, Bundesamt für Statistik, 1997.
14 Uchtenhagen A: Zum Stellenwert der stationären abstinenz-orientierten Therapien – Gestern und heute; in Grichting E, Uchtenhagen A, Reichlin M, Rehm J (eds): Stellenwert und Klientele stationärer abstinenz-orientierter Therapien für Drogenabhängige in der Schweiz: Abschlussbericht der Koordinationsstelle des Forschungsverbundes stationäre Suchttherapie FOS zur 'FOS-Basisdokumentation' in den Jahren 1997 bis 2000. Forschungsbericht aus dem Institut für Suchtforschung. Zürich, Institut für Suchtforschung, 2001.
15 Uchtenhagen A: Erkenntnisse aus einigen Behandlungsansätzen und Behandlungsverfahrungen; in Böker W, Nelles J (eds): Drogenpolitik wohin? Sachverhalte, Entwicklungen, Handlungsvorschläge, ed 2. Bern, Haupt, 1992, pp 221–232.
16 Herrmann H, Güntzel O, Simmel U, Lehmann P: Stationäre Suchttherapie Schweiz: Angebot und Finanzierung. Gesamtschweizerische Erhebung im Alkohol- und Drogenbereich für die Jahre 1995–1998. Bern, Bundesamt für Gesundheit, 1999.
17 Dobler-Mikola A, Grichting E: Evaluation stationärer Suchttherapien für Drogenabhängige: Der Forschungsverbund stationäre Suchttherapie (FOS). Bull Bundesamt Gesundheit 1999; 23:407–410.
18 Grichting E, Uchtenhagen A, Reichlin M, Rehm J: Stellenwert und Klientele stationärer abstinenz-orientierter Therapien für Drogenabhängige in der Schweiz: Abschlussbericht der Koordinationsstelle des Forschungsverbundes stationäre Suchttherapie FOS zur 'FOS-Basisdokumentation' in den Jahren 1997 bis 2000. Forschungsbericht aus dem Institut für Suchtforschung. Zürich, Institut für Suchtforschung, 2001.